STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085002	A. BUILDING _____ B. WING Director's Office FEB 02 2010	C 12/18/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW NURSING "revised"	2801 W. 6TH STREET WILMINGTON, DE 19805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from December 7, 2009 through December 18, 2009. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other documentation as indicated. The facility census the first day of the survey was 136. The survey sample included 40 census residents, 30 admission residents, and 28 stage 2 residents. Additionally, there were three subsampled residents (SSR1, SSR2, & SSR3) who were reviewed in stage 2.	F 000	Disclaimer Statement Preparation and/or execution of this plan of correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged	F 225		

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Deborah J. Kaufman — Administrator — 1/29/10 1/25/10

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

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F 225	Continued From page 1 violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on clinical record review, review of other facility documents and staff interview, it was determined that the facility failed to ensure that 2 residents (R100 and SSR1) out of 31 stage 2 sampled residents, who had allegations for potential abuse and neglect of care were reported to the State agency, the Division of Long Term Care Residents Protection (DLTCRP) and were thoroughly investigated. R100 sustained skin tear to her left shin during transfer from a wheelchair to a shower chair and lacked a through investigation. SSR1's report of potential allegation of abuse lacked evidence that the allegation was reported to the DLTCRP and was thoroughly investigated. Findings include: The facility's Investigation Protocol was reviewed. 1. According to R100's Minimum Data Set (MDS) assessment dated 8/24/2009, this resident was dependent of staff (needed extensive assistance of 1 person) for transfer between surfaces; to/from wheelchair to chair and standing position.	F 225		

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F 225	Continued From page 2 A nurse's note dated 8/11/09 and timed 2:30 PM stated. "Res. acquired skin tear to L (left) shin while transferring from w/c to shower chair measuring 2.0 cm x 2.0 cm". Resident 100's "Incident/Accident Report" dated 8/11/09 stated "Resident sustained a skin tear to left shin this am during care..." Review of the facility's "Investigative Protocol" summary dated 8/11/09 stated that "Resident stood to transfer from w/c to shower chair and hit (L) shin on footrest of w/c (wheelchair)causing a skin tear". The facility's "Incident Report Investigation Summary" dated 8/12/09 stated "Resident transfer self with staff supervision from wheelchair to shower chair, hit her left shin on the foot rest, sustained 1x1x0.1 (1x1 cm) skin tear". This skin tear measurement was not consistent with the nurse's note description dated 8/11/09. Additionally, in an interview with E10 (C.N.A.) on 12/17/09, it was revealed/clarified that E10 was attempting to put the left foot rest up so resident can stand up. During the process, R100 suddenly placed her left foot down on the floor to stand and hit her left leg on the foot rest and caused the skin tear. Documentation of the exact nature of this incident was not provided. The investigation was not thorough since it did not include complete, accurate data collection and analysis for this resident who required the assistance of 1 staff/person to transfer instead of a "staff supervision". In addition, the result of the investigation did not provide appropriate follow-up intervention to prevent further accidents as per facility's investigative protocol.	F 225	F 225 #1 1. The resident was given first aid at the time of the incident. 2. An audit was completed to ensure that all incidents were completely and accurately investigated. 3. All investigations will be reviewed by the administration team (Administrator, DON, ADON) daily. 4. The corporate consultants will review all investigations to ensure completeness monthly.	8/11/09 1/10/10 Ongoing Ongoing

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F 225	Continued From page 3 2. Review of SSR1's nurse's notes, dated 5/3/09 and timed 11 PM stated, "... Alert & oriented X (times) 1. Cont (Continues) c (with) periods of confusion & agitation. Taken meds c difficulty. Frequently refuses and must be approached X 3 to finally take meds. Became verbally & physically abusive towards staff! Was being taken down the hallway to the B.R. (bathroom) when she suddenly yelled "Help! She's kidnapping me!" Told this nurse "You hit me twice!" while trying to toilet her. ..." Findings were discussed with E2, the Director of Nursing, during an interview on 12/18/09. E2 confirmed that the allegation of abuse was never reported to DLTCRP (State agency) nor investigated. She stated that the resident is on a "dementia unit." The nurse involved, E14, knew the resident was "confused" and most likely did not view the resident's statements as credible and or as an allegation of abuse. Although E2 was adamant that no abuse took place, she acknowledged that "technically" SSR1's statements should have been treated as an allegation of abuse. The facility failed to identify SSR1's statement, "You hit me twice" as an allegation of abuse. Therefore, they failed to report or investigate this allegation of abuse.	F 225	#2 1. The resident involved is no longer in the facility. 12/18/09 2. A random audit of resident charts was completed to ensure that all allegations of abuse were reported. 1/10/10 3. In servicing will be provided on abuse/neglect to all staff. 2/18/10 4. Ongoing audits and education will be completed by the staff educator until substantial compliance is reached. Ongoing	
F 241 SS=D	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	F 241		

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F 241	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation and interview, it was determined that the facility failed to ensure that one (1) resident (R6) out of 31 stage 2 sample residents, received the care in a manner and in an environment that maintained/enhanced her dignity and respect in full recognition of her individuality. R6 was transported to her scheduled physician's electromyography (EMG) appointment covered only with a blanket wearing only an adult incontinent brief and not wearing any other clothing. Findings include: Interview with E12 (LPN) on 12/15/09 revealed the facility's procedure for transporting residents to their appointment was as follows: Residents' scheduled for an outside medically related appointment had their names listed in the units's appointment book. The CNAs were also informed during the morning report of the resident's scheduled appointment. The CNA assigned to the resident had to get the resident ready, groomed, washed, dressed, briefs changed and all ready for pickup at the scheduled time. R6 had diagnoses that included genetic mental disorder, depression, neuropathy, bursitis of the right shoulder, obesity, ambulatory dysfunction, paralysis, post meningococcal meningitis, right hand pain and weakness. According to R6's Minimum Data Set (MDS) assessments, dated 2/25/09 and 5/11/09, this resident's cognitive skills for daily decision-making were "independent" and had no short or long term memory problem. R6 needed	F 241	F 241 1. The incident was reviewed and investigated by the DON. Findings showed that the resident was not dressed appropriately for her appointment.. 2. The procedure for resident appointments was changed so the each unit manager is responsible for checking each resident before they leave the building to ensure that they have received the appropriate care and are dressed appropriately. 3. Transportation aide will monitor and ensure that the resident is dressed appropriately and unit manager has checked the resident prior to leaving the facility. 4. DON/designee will monitor that procedure is being followed for each outside appointment.	4/1/09 Ongoing Ongoing Ongoing

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F 241	Continued From page 5	F 241		

extensive assistance with her ADLs, 2 person assist for transfers and hygiene and she was totally dependent on staff for dressing. R6 was incontinent of bowel and bladder. R6 was observed to be wheelchair bound.

The facility originally developed a care plan dated 8/21/07 (revised/reinitiated on 5/7/09) on "Self Care deficit r/t (related to) paralysis d/t (due to) history of meningococcal meningitis, CVA (stroke) and morbid obesity". The interventions included: "consistent daily routine", "Set up basin, towel, and washcloth for AM and PM care and task (R6) to start care", "Allow her to choose her own clothes and assist her with fixing her hair as she requests".

On 12/15/09 at 9:50 AM R6 was observed in bed, asleep. In an interview with E13 (CNA) on 12/15/09 at 9:50 AM, she stated that R6 wakes up at 10:30 AM daily and her AM care was provided at 11:00 AM. R6 routinely sleeps at night without any clothes on and only wore an adult incontinent brief during the night.

A nurse's note dated 3/31/09 (12:20 PM) stated, "Resident left for EMG appt. (appointment) via ...ambulance via stretcher".

During an interview with R6 on 12/14/2009 at 3:50 PM, she stated that when she went out to her EMG appointment via stretcher she was covered with a bed sheet/blanket, without any clothes on and wore only a urine soaked adult incontinent brief. She also stated that she had not been washed and her hair was not combed. She stated that she was embarrassed when she arrived at the physician's office.

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F 241	Continued From page 6 R6's CNA ADL Flow Care sheet showed that the CNAs signed off on all shifts on 3/31/09 that R6 was turned and repositioned every 2 hours and skin checks were done every 2 hours. However, during the every 2 hours checks, the assigned CNA signed off R6's care prior to her scheduled appointment, failed to ensure that R6 was washed, had the appropriate clothing on, had a clean adult incontinent brief on and was ready to be sent out for her appointment. Review of the facility's "Incident Report Investigation Summary" dated 3/31/09 stated, "...Resident was asked 4 x (times) if she needed anything prior to appointment at no time did resident say that she did not have gown on. Resident was covered from neck to toes with sheets and blankets. All staff interacting with resident thought she had a gown on underneath blankets". In an interview with E11 (LPN unit manager) on 12/17/09 at approximately 9:45 AM, she stated that prior to leaving the facility, the CNA who was assigned to care for R6 did not report to her that R6 had not been washed and dressed appropriately and had not had her adult incontinent brief changed. E11 noticed that R6's blanket was pulled up while on a stretcher and she assumed that R6 was ready. E11 stated that she did not "take the extra mile" to check if R6 was appropriately ready. E11 acknowledged that R6 was sent out to the physician's office for an EMG without her clothes on.	F 241		
F 253 SS=B	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 253		

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F 253	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observations during the environmental tour with maintenance and housekeeping staff (E4 and E5) on 12/10/09 at 10:35 AM, it was determined that the facility failed to provide maintenance and housekeeping services necessary to maintain an orderly interior. Findings include: On 12/10/09, the following observations were made in the facility: - Unpainted plaster was observed on the walls of resident rooms #102 and #407. - Nine dirty ceiling tiles were observed in different areas such as resident rooms#:102,109, 406 (2), 407(2), the beauty parlor (2), and in the hallway outside room 407. Additionally, streaks of yellow paint in the white ceiling of room 101 was observed. - Missing closet doors were observed in resident room #317 and #320A. - A dirty floor mat was observed in resident room 205B on 12/7/09 and 12/10/09. The floor mat of resident room 406 was observed dusty. - The window blind of resident room #310 was in disrepair. -Observation of the bathroom in resident room #406 revealed a wall tile in disrepair. - Observation of the swinging door from the 400 unit to the main dining room revealed heavy black marks on the bottom part of the door. Housekeeping staff interview (E5) on 12/10/09 at 11:30 AM confirmed these findings.	F 253	F 253 1. All areas identified on 2567 were immediately repaired/replaced during survey with exception to missing closet doors. Temporary curtains were hung due to timing of expected start date of renovations being 6/1/10. 2. Maintenance will conduct an audit of all units to determine areas of repair. 3. Areas of repair will be added to Monthly Maintenance Log. 4. Monthly Maintenance Log will be maintained by Maintenance Supervisor and/or designee. The report will be given to the Administrator and presented at quarterly QI committee meeting as repairs are completed.	12/18/09 2/18/10 2/18/10 Ongoing
F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment	F 279		

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F 279	Continued From page 8 to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined that the facility failed to ensure that a comprehensive care plan was developed for one (1) resident (R89) out of 31 that addressed the residents' needs. While the facility care planned for the side effects of the psychotropic medication the facility failed to care plan for R89's behaviors and implementation of non-pharmacological interventions before administering Ativan. Findings include: Diagnoses for R89 included dementia with behavioral dyscontrol. Review of physician's orders revealed that on 6/1/09 an order was written for R89 to receive Lorazepam (antianxiety) Gel 0.5mg/0.1ml every 6 hours as needed	F 279		

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F 279	Continued From page 9 secondary to behavioral dyscontrol. A care plan was developed on 9/19/09 for the potential for side effects of psychotropic medications. The facility failed to list specific side effects (including behaviors) related to the medications and they failed to identify how they were going to monitor for effectiveness and side effects of the medications. The facility failed to identify and list ways in which to reduce and/or eliminate R89's behaviors and they failed to list non-pharmacological interventions to consider/use before administering Lorazepam to R89. On 12/17/09 at 10:30 AM during an interview with E2 (DON), E2 acknowledged that the care plan failed to include interventions to be attempted by staff prior to use of Lorazepam and lack of indication for it's use on several occasions.	F 279	F 279 1. Resident R89's medications and care plan were reviewed and revised. Appropriate interventions were added to the care plan to assist staff prior to medicating resident. 2. A random audit was completed to ensure all residents receiving psychotropic medications had appropriate non-medical interventions in use prior to being medicated and care plans were accurate. 3. All nurses will be in serviced on the importance of initiating non-medicinal behavioral interventions prior to initiating medications as a last resort. 4. A quarterly QI audit will be completed by the Social Services Director to ensure that care plan's include appropriate interventions and to ensure that the interventions are initiated and documented. This QI will continue until substantial compliance is reached.	1/10/10 1/10/10 2/18/10 Ongoing
F 280 SS=D	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed	F 280		

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F 280	Continued From page 10 and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation and interview, it was determined that the facility failed to revise 1 resident's (R64) out of 31 stage 2 sampled residents, care plan related to his need for a dental service referral for evaluation of identified oral/dental health problems. Findings include: The facility developed a care plan for R64 dated 11/4/2008 on "Care deficit pertaining to the teeth or oral cavity characterized by: "altered oral mucous membrane; problems with dentures/teeth/gums related to: deterioration of support structure, poor oral hygiene, carious teeth". The interventions listed were: Instruct resident in proper oral hygiene; provide supplies for oral hygiene; Assist with oral hygiene as necessary; Oral assessment to be completed quarterly". A quarterly assessment dated 9/8/09 indicated that R64 has "generalized breakdown noted on few remaining teeth (3 on bottom)". The care plan was last reviewed on 11/18/09. Additionally, the facility performed a quarterly "Oral Assessment" on 11/19/09 and identified the missing teeth. The facility failed to revise the care plan related to his need for routine dental examinations/referral for evaluation of identified oral/dental health problem such as notifying the attending physician	F 280	F 280 1. Resident R64 was immediately offered a dental consult which he adamantly refused. 2. All residents were assessed for dental needs, referral to dentists were made as appropriate. 3. All residents with their own teeth will be referred to dentist for routine dental care as desired. 4. A quarterly QI will be put into place to ensure that all residents have been offered and/or scheduled for dental care. This will be monitored by the DON/designee until substantial compliance is reached.	12/18/09 1/10/10 Ongoing Ongoing

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F 280	Continued From page 11 of resident's need for dental treatment and to order a dental consultation as appropriate.	F 280		
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined that the facility failed to provide one (1) resident (R151) out of 31 sampled Stage 2 residents the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the plan of care. The facility failed to ensure that physician's orders for fluid restriction were followed for R151. Findings include: R151 was re-admitted to the facility, after a hospitalization, on 12/3/09. R151's diagnoses included end stage renal disease which required hemodialysis three (3) times a week. Re-admission orders, dated 12/3/09, indicated that R151 was to be on a 1500 ml (milliliters) fluid restriction per day. R151's care plan entitled, "Renal Impairment-dialysis dependent. End stage renal disease" stated, "...Assess weight and fluid restriction status as ordered..." The "Nutrition Risk Assessment," completed by the Registered	F 309		

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	085002	A. BUILDING _____ B. WING _____	C 12/18/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW NURSING	2801 W. 6TH STREET WILMINGTON, DE 19805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 12 Dietitian (RD) on 12/7/09, stated that R151 was on a 1500 ml fluid restriction, but failed to indicate the allotted amount of fluids for dietary and nursing. Review of the clinical record revealed that while the facility was monitoring meal intakes, it lacked evidence that other fluids given, such as during medication administration and supplements, were being monitored. Review of the medication and treatment records from 12/3/09 through 12/12/09 failed to even indicate that R151 was on a fluid restriction. R151 was observed during the morning meal on 12/10/09 at 8:30 AM. The meal ticket stated, "Give 8 oz. (ounces) coffee and 8 oz. milk on fluid restriction." Observation revealed that R151 had in addition to the 8oz of coffee and 8 oz of milk, a 4 oz. container of apple juice on his tray, which he had consumed. Review of nurse's notes from 12/3/09 through 12/12/09 failed to indicate that R151's fluid restriction was being maintained. Contrary to the fluid restriction order, nurse's notes on 12/4/09, 12/10/09 and 12/12/09 stated that fluids were being "encouraged/offered" with no indication that total 24 hour amounts were being monitored. During an interview with E7 (Registered Dietitian) on 12/17/09 at 5:15 PM she acknowledged that it was not noted anywhere in the record what the allotments were for fluids over a 24 hour period. E7 also stated that monitoring was to be done with an I & O (Intake and Output) sheet. On 12/18/09 at 1:30 PM during an interview with E2 (DON), E2 acknowledged that the facility failed to monitor the fluid restriction requirements for R151.	F 309	F309 1. Resident R151 is no longer on fluid restrictions. 12/18/09 2. All residents on fluid restrictions were audited to ensure allocations of fluid were documented properly. 1/10/10 3. Dietitian will monitor all residents on fluid restrictions weekly to ensure compliance with restrictions. In servicing will be provided for nursing staff on the proper recording of fluid intake. 2/18/10 4. Results will be presented at quarterly QI meeting until substantial compliance is met. Ongoing	
F 329	483.25(l) UNNECESSARY DRUGS	F 329		

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F 329 SS=D	Continued From page 13 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, it was determined that the facility failed to ensure that two (2) residents (R11 and R89) out of 31 sampled Stage 2 resident's drug regimens were free from unnecessary drugs. The facility failed to ensure that R11's lipid profile was monitored for the effectiveness of a cholesterol lowering medication. The facility failed to have an indication for use of Ativan (anti-anxiety medication) for R89 on 11 occasions. Findings	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW NURSING	2801 W. 6TH STREET WILMINGTON, DE 19805

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F 329	Continued From page 14 include: 1. R11 was originally admitted to the facility on 7/14/06 and had diagnoses that included hypertension and hyperlipidemia. The 12/09 monthly physician's order sheet (POS) revealed that R11 was receiving Pravastatin (lipid lowering drug) daily and was ordered to have a lipid profile drawn every 6 months in May and November. Review of the clinical record revealed that the last lipid profile had been drawn on 5/20/09. There was no evidence that the 11/09 lipid profile had been drawn as ordered to monitor the effectiveness of the Pravastatin. During an interview with E19 (nurse) on 12/10/09 at 10:30 AM, E19 contacted the laboratory, which confirmed that a lipid profile had not been drawn since 5/09. Subsequently, an order was written for R11 to have a lipid profile drawn in the morning. 2. R89 was admitted to the facility on 7/29/08 and had diagnoses that included dementia with behavior dyscontrol and anxiety and a history of falls. Review of physician's orders revealed that on 6/1/09 an order was written for R89 to receive Lorazepam (used for anxiety disorder) Gel 0.5mg/0.1ml every 6 hours as needed secondary to behavioral dyscontrol, agitation/anxiety. A care plan for the problem, "Potential for side effects of psychotropic medications," was initiated on 9/19/09. This care plan failed to include non-pharmacological interventions to be implemented prior to administration of the Lorazepam.	F 329	F 329 #1 1. Lab was immediately obtained when identified by surveyor. 2. All lab orders audited to ensure results obtained as order specified. 3. In servicing will be provided on identifying results and appropriate follow through. 4.Initiate QI to be monitored by DON/designee until substantial compliance is met. #2 1. Resident R89 medication and care plan was reviewed and revised. Care plan was updated with appropriate interventions to be used prior to medicating for behaviors. 2. An audit was completed on all residents receiving prn psychotropic medications to ensure care plan compliance and accuracy of documentation. 3. In servicing will be provided to all nurses on importance of initiating non-pharmacological interventions prior to medicating for behavioral discontrol. 4. DON/designee will monitor and present results at quarterly QI until substantial compliance is met.	12/11/09 1/10/10 2/18/10 Ongoing 12/18/09 12/18/09 2/18/10 Ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 329	Continued From page 15 Medication records, nurse's notes and CNA (Certified Nurse Aide) behavior flowsheets reviewed from 9/1/09 through 11/30/09 failed to indicate on 11 occasions that R89 had behaviors that warranted the use of the Lorazepam. Additionally, there was no evidence that any non-pharmacological interventions had been attempted prior to the administration of the Lorazepam. During an interview with E11 (nurse) on 12/15/09 at 2:30 PM, E11 stated that when a medication such as Lorazepam is given, the staff is to attempt non-pharmacological interventions prior to giving the medication. E11 also stated that the nurse is to document the interventions that had been attempted in a nurse's note. On 12/17/09 at 10:30 AM during an interview with E2 (DON), she acknowledged that there was a lack of evidence that warranted the use of the Lorazepam on the 11 occasions from 9/09 through 11/09.	F 329		
F 333 SS=D	483.25(m)(2) MEDICATION ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, review of other documentation as indicated and interview, it was determined that the facility failed to be free of significant medication errors for one one (1) resident (R100) out of 31 stage 2 census sampled residents. R100 failed to receive 12 doses of Levsin (excessive secretions) as ordered from 11/1/09 through 11/6/09. Findings include:	F 333		

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F 333	Continued From page 16 R100 had diagnoses that included dementia with anxiety, esophageal reflux, history of lung CA and dysphagia. According to R100's Minimum Data Set (MDS) assessment dated 11/3/09, this resident's cognitive skills for daily decision-making were "modified independence-some difficulty in new situations only" and had a short and long term memory problem. R100 needed extensive assistance with her ADLS (activities of daily living). According to the Physician's Order sheet, on 3/29/09, R100 was originally prescribed and received "Levsin 0.125 mg. PO BID (by mouth twice a day)". A new order was written on 10/29/09 for "Levsin 0.125 mg SL (sublingual) BID". Review of the 11/09 MAR, revealed that it was not signed off as administered twice a day from 11/1/09 through 11/6/09. A nurse's note dated 11/7/09 stated, "Levsin BID not transferred to MAR (Medication Administration Record); Dosage missed x 6 days". Review of the November 2009 MAR revealed that 12 doses of Levsin were not received by R100 from 11/1/09 through 11/6/09. Review of the "Medication Incident Report" provided to the surveyor by E2 (DON) indicated that the "Order for levsin 0.125 mg PO BID was not transcribed onto the November (2009) MAR, consequently the Levsin medication was not administered to R100 for 6 days or 12 doses.	F 333	F333 1. Medication was immediately initiated when error was identified. Nurse responsible was counseled. 11/8/09 2. Facility wide audits were conducted to ensure accuracy of POS and MAR. 1/10/10 3. In servicing was provided to 11-7 nursing staff on thorough chart check procedures. 2/18/10 4. DON/designee will conduct audits on monthly change over of POS/MAR accuracy. Audits will be presented at quarterly QI meetings until substantial compliance is met. Ongoing	
F 371 SS=B	483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food	F 371		2/18/10

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	085002	A. BUILDING FEB 17 2010 B. WING Director's Office	C 12/18/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 371	Continued From page 17 under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and procedure review, it was determined the facility failed to protect food during preparation and distribution. Findings include: 1. On 12/7/09 at 8:30 AM, observation of a bucket containing a neutralizer solution used to clean and sanitize kitchen surfaces was sitting by the kitchen steam table. Surveyor requested the solution be tested to determine the amount of sanitizer in the solution. Interview with dietary staff (E6) revealed that they had no way to test the solution. On 12/10/09, interview with the dietary staff E6 revealed that they are supposed to be using the same sanitizing solution found in the three compartment sink to sanitize the surfaces of equipment in the kitchen. Procedure review on 12/10/09 revealed that all surfaces in the kitchen were to be sanitized. Follow-up interview with the chemical manufacturer's representative on 12/29/09 revealed that this chemical is inappropriate for use in sanitizing contact food surfaces, and was recommended for floor cleaning. 2. On 12/7/09 at 10:05 AM, a dietary staff was observed in the kitchen with the hair covered half way (pony tail only). On 12/17/09 during dinner time, a dietary staff (E8) was observed working at the steam table without a hair restraint.	F 371	F371 #1 1. Solution identified during observation is used for general purpose cleaning not for sanitizing kitchen surfaces. At time of observation, general purpose cleaning was being conducted. Implementation of next step to sanitize kitchen surfaces was followed. 2. Food Service Director will have chemical distributor add a sanitizing solution to the chemical command center to ensure sanitation step is performed regardless of area. 3. In servicing to dietary staff will be provided for distribution of new cleaning solution and procedures. 4. Audits for proper use of solution will be conducted by Food Service Director and reported to quarterly QI committee until substantial compliance has been met. #2 1. Dietary staff E8 was addressed about observation of working without a hair restraint. 2. Monitoring will be conducted by the Food Service Director on proper placement and use of hair restraint. 3. In servicing will be provided to all dietary staff on the importance of hair restraint and the negative outcomes that can be associated without the use of the hair restraint. 4. Food Service Director will present results at quarterly QI meeting until substantial compliance has been met.	12/7/09 2/18/10 2/18/10 Ongoing 12/17/09 Ongoing 2/18/10 Ongoing
F 412	483.55(b) DENTAL SERVICES - NF	F 412		12/17/09

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F 412 SS=D	Continued From page 18 The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, it was determined that the facility failed to ensure that 1 resident (R64) out of 31 stage 2 sampled residents, received services or obtained from outside resources routine dental services to meet his needs, arranged for transportation to and from the dentist's office and promptly referred this resident with carious teeth to a dentist. Findings include: The facility's policy entitled "Dental Services-Oral healthcare and dental services will be provided to each resident" was reviewed. The facility conducted oral assessments to R64 dated 9/8/09 and identified this resident to have "generalized breakdown" on few remaining teeth (3 teeth on bottom). Another oral assessment, dated 11/19/09 stated, "Pt. (patient) has 3 teeth on bottom. Both oral assessments did not address the need for a follow-up with attending physician of R64's need for dental treatment and order dental consultation as appropriate. In addition, there was a lack of documentation by	F 412	F 412 1. Resident R65 identified during survey was asked if he would like a dental consultation. Resident R64 refused all care for dental services. 12/17/09 2. Unit Managers will ask at time of quarterly assessment if dental services are desired. Ongoing 3. Unit Managers will inform Social Services of request and/or refusal of outcome from quarterly assessment. Ongoing 4. Social Services will monitor and present results at quarterly QI meeting. Ongoing	

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F 412	Continued From page 19 the attending physician of an assessment of the resident's dental need and findings in the resident's medical record. The completed "Oral Assessment", dated 11/19/09 identifying that "patient has 3 teeth on bottom" addressed under "Recommendations" None required and did not identify the need for a "Follow up with M.D. for Dental Consult". In an interview with E15 (RN) on 12/17/09 she acknowledged that dental services were not provided and/or required and that a follow-up was needed because R64 refused. E15 acknowledged that there was no documented evidence of causal factors for refusal. There was no documented evidence that resident was asked to be referred to a dentist and that resident refused. Additionally, it was not reported to Social Service for a follow-up to encourage R64 if he refused. In an interview with E16 (Social Service Director) on 12/17/09 at 1:45 PM, she acknowledged that she was not informed of resident's need for a dental consult or resident's condition and his refusal to see a dentist.	F 412		
F 441 SS=D	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 441	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that infection control program designed to provide a safe, sanitary and comfortable environment to prevent the development and transmission of disease and infection was maintained. Findings include: Based on observation on 12/8/09 at 11:00 AM, it was observed that 2 CNAs, E17 and E18 left unbagged soiled linens on the floor used during provision of ADL care in room 301C. In an interview with E17 and E18 on 12/8/09, both CNAs acknowledged this finding.	F 441	F 441 1. C.N.A., E17 and E18 observed during survey handling soiled linens improperly was addressed immediately. 2. Random observations will be done by administrative staff to ensure proper handling of soiled linens. Staff will be counseled if found not following protocol. 3. In servicing was provided for C.N.A.'s involved by DON and disciplinary action taken. Rein servicing will be provided for all C.N.A.'s for proper handling of soiled linens. 4. DON/designee will monitor all staff to ensure proper handling of soiled linens until substantial compliance is met.	12/8/09 Ongoing 2/18/10 Ongoing

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

LTC Residents Protection
FEB 02 2010
Director's Office

STATE SURVEY REPORT

NAME OF FACILITY: Parkview Nursing Home

DATE SURVEY COMPLETED: December 18, 2009

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual and complaint survey was conducted at this facility from December 7, 2009 through December 18, 2009. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other documentation as indicated. The facility census the first day of the survey was 136. The survey sample included 40 census residents, 30 admission residents, and 28 stage 2 residents. Additionally, there were three subsampled residents (SSR1, SSR2, & SSR3) who were reviewed in stage 2.	"REVISED" Disclaimer Statement Preparation and/or execution of this plan of correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.
3201	**Regulations for Skilled and Intermediate Nursing Facilities**	
3201.6.0	**Services To Residents**	
3201.6.1	**General Services**	
3201. 6.1.1	**The nursing facility shall provide to all residents the care necessary for their comfort, safety and general well-being, and shall meet**	

Provider's Signature [signature] Title Administrator Date 1/25/10 1/29/10

NAME OF FACILITY: Parkview Nursing Home

DATE SURVEY COMPLETED: December 18, 2009

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	their medical, nursing, nutritional, and psychosocial needs. **This requirement is not met as evidenced by:** Cross refer to CMS 2567-L, survey date completed 12/18/09, F309, and F412.	**Cross Refer to CMS 2567-L, F309 and F412**
3201.6.5	**Nursing Administration**	
3201. 6.5.6	**A comprehensive care plan shall be developed to address medical, nursing, nutritional and psychosocial needs within 7 days of completion of the comprehensive assessment. Care plan development shall include the interdisciplinary team that includes the attending physician, an RN/LPN and other appropriate staff as determined by the resident's needs. With the resident's consent, the resident, the resident's family or the resident's legal representative may attend care plan meetings.** **This requirement is not met as evidenced by:** Cross refer to CMS 2567-L, survey date completed 12/18/09, F279	**Cross Refer to CMS 2567-L, F279**
3201. 6.5.7	**The assessment and care plan for each**	

NAME OF FACILITY: Parkview Nursing Home

DATE SURVEY COMPLETED: December 18, 2009

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	resident shall be reviewed/revised as needed when a significant change in physical or mental condition occurs, and at least quarterly. A complete comprehensive assessment shall be conducted and a comprehensive care plan shall be developed at least yearly from the date of the last full assessment. **This requirement is not met as evidenced by:** Cross refer to CMS 2567-L, survey date completed 12/18/09, F280.	**Cross Refer to CMS 2567-L, F280**
3201. 6.8	**Food Service**	
3201. 6.8.1	**Meals**	
3201. 6.8.1.3	**When residents refuse a meal served, substitutes of similar nutritive value shall be offered.** **This requirement is not met as evidenced by:** Cross refer to CMS 2567-L, survey date completed 12/18/09, F246.	F 246 1. Resident R6 identified as receiving turkey and requesting "no turkey" was immediately addressed with dietary department. Resident R6 did not request any other meal due to the fact her family had provided her with dinner on this particular day. 12/15/09 2. Dietitian and./or designee will conduct random audits to ensure residents are receiving preferences as indicated on their dietary slip. 2/18/10 3. In servicing will be provided with the dietary department to educate on resident choices vs. dietary decisions. 2/18/10 4. Results will be presented at quarterly QI meeting until substantial compliance is met. Ongoing
3201. 6.9	**Housekeeping and Laundry Services**	
3201. 6.9.1	**The facility shall employ sufficient**	

NAME OF FACILITY: Parkview Nursing Home

DATE SURVEY COMPLETED: December 18, 2009

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	housekeeping personnel and provide the necessary equipment to maintain a safe, clean, and orderly environment, for the interior and exterior of the facility. **This requirement is not met as evidenced by:** Cross refer to CMS 2567-L survey report date completed 12/18/09, F253, F441.	**Cross Refer to CMS 2567-L, F253 and F441**
3201. 6.11	**Medications**	
3201. 6.11.1	**Medication Administration**	
3201. 6.11.1.1	**All medications (prescription and over-the-counter) shall be administered to residents in accordance with orders which are signed and dated by the ordering physician or prescriber. Each medication shall have a documented supporting diagnosis. Verbal or telephone orders shall be written by the nurse receiving the order and then signed by the ordering physician or prescriber within 10 days.** Cross refer to CMS 2567-L, survey date completed 12/18/09, F333 and F329.	**Cross Refer to CMS 2567-L, F333 and F329**
3201.7.5	**Kitchen and Food Storage Areas**	
3201.7.5.1	**Facilities shall comply with the Delaware Food**	

NAME OF FACILITY: Parkview Nursing Home

DATE SURVEY COMPLETED: December 18, 2009

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	Code **This requirement is not met as evidenced by:** **3-304.14 Wiping Cloths, Use Limitation.** **(B) Cloths used for wiping food spills shall be: (2) Wet and cleaned as specified under ¶ 4-802.11(D), stored in a chemical sanitizer at a concentration specified in § 4-501.114, and used for wiping spills from food-contact and nonfood-contact surfaces of equipment.** **This requirement is not met as evidenced by:** Cross refer to CMS 2567-L survey report date completed 12/18/09, F371, Example #1. **Hair Restraints** **2-402.11 Effectiveness** **(A) Except as provided in ¶ (B) of this section, food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens; and**	**Cross Refer to CMS 2567-L, F371, Example #1**

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	unwrapped single-service and single-use articles. **(B) This section does not apply to food employees such as counter staff who only serve beverages and wrapped or packaged foods, hostesses, and wait staff if they present a minimal risk of contaminating exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles.** **This requirement is not met as evidenced by:** Cross refer to CMS 2567-L survey report date completed 12/18/09, F371, Example #2.	**Cross Refer to CMS 2567-L, F372, Example #2**
3201. 10.0	**Records and Reports**	
3201. 10.5	**Incident reports, with adequate documentation, shall be completed for each incident. Adequate documentation shall consist of the name of the resident(s) involved; the date, time and place of the incident; a description of the incident; a list of other parties involved, including witnesses; the nature of any injuries; resident outcome; and follow-up action, including notification of the resident's representative or family, attending physician and licensing or law**	

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	enforcement authorities, when appropriate. **This requirement is not met as evidenced by:** Cross refer to CMS 2567-L, survey completed 12/18/09, F225.	**Cross Refer to CMS 2567-L, F225**
3201. 10.8	**Reportable incidents are as follows:**	
3201. 10.8.1	**Abuse as defined in 16 Delaware Code, §1131.**	
3201.10.8.1.1	**Physical abuse with injury if resident to resident and physical abuse with or without injury if staff to resident or any other person to resident.** **This requirement is not met as evidenced by:** Cross refer to CMS 2567-L, survey completed 12/18/09, F225.	**Cross Refer to CMS 2567-L, F225**
16 Del.C., Chapter 11, Subchapter II, §1121	**Patient's rights.** **It is the intent of the General Assembly, and the purpose of this section, to promote the interests and well-being of the patients and residents in sanitoria, rest homes, nursing homes, boarding homes and related institutions. It is declared to be the public**	

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	policy of this State that the interests of the patient shall be protected by a declaration of a patient's rights, and by requiring that all facilities treat their patients in accordance with such rights, which shall include but not be limited to the following: **(1) Every patient and resident shall have the right to receive considerate, respectful, and appropriate care, treatment and services, in compliance with relevant federal and state law and regulations, recognizing each person's basic personal and property rights which include dignity and individuality.** **This requirement is not met as evidenced by:** Cross refer to CMS 2567-L, survey completed 12/18/09, F241.	**Cross Refer to CMS 2567-L, F241**